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JAN 5 1976

IN THE

SUPREME COURT OF THE UNITED STATES

JANUARY TERM, 1975

No. 74-1151

PLANNED PARENTHOOD OF CENTRAL MISSOURI, a Missouri Corporation, DAVID HALL, M.D., and MICHAEL FREIMAN, M.D.,
Appellants,

vs.

JOHN C. DANFORTH, Attorney General of the State of Missouri, and J. BRENDON RYAN, Circuit Attorney of the City of St. Louis, Missouri,
Appellees.

On Appeal from the United States District Court for the Eastern District of Missouri, Eastern Division

MOTION OF MISSOURI NURSES FOR LIFE FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE IN SUPPORT OF APPELLEES WITH BRIEF ANNEXED

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MOTION OF MISSOURI NURSES FOR LIFE FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE IN SUPPORT OF APPELLEES

Missouri Nurses for Life is a non-sectarian inter-disciplinary state wide organization of licensed professional nurses dedicated to promoting the quality and dignity of all human life. Missouri Nurses for Life affirms the responsibility of all health care personnel to support and sustain life. And are resolved to assist those doctors, nurses and health care workers who are being discriminated against or denied the opportunity to practice their

profession according to the dictates of their conscience because of their belief in the inalienable right to life and their respect for all human life.

Each of its 300 members is a Professional Nurse, licensed to practice nursing in the State of Missouri. Its members are employed in both public and private hospitals, and are both private duty and general duty nurses practicing different nursing specialties at both the administrative and staff levels.

Nurses are an integral part of the overall health service operation. The nurse-patient relationship is unique and frequently involves a more prolonged and closer personal association than the patient may have with her doctor.

Missouri Nurses for Life are concerned that the particular viewpoint of nurses with respect to the propriety of the legislation now under scrutiny in this case will not be heard or considered. Amicus feels that the development of the nurses' position with regard to House Bill 1211 is essential to and will assist the Court in a proper determination of the issues raised on this appeal. For these reasons, Missouri Nurses for Life ask leave of this Court to file an Amicus Curiae Brief in support of the Appellees.

The consent of Appellee has been obtained and has been filed with this Court. The consent of Appellant has been requested and such consent was not granted.

Respectfully submitted

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BRIEF AMICUS CURIAE OF MISSOURI NURSES FOR LIFE IN SUPPORT OF APPELLEES

STATEMENT OF INTEREST

Nursing is basically a caring profession, whose ethical code, in its various versions, has always been supportive of human life and the dignity of man. While the nurse frequently carries out the physician's orders and cooperates in his activities, "neither physicians nor the employing agencies' policies relieve the nurse

of the responsibility for her own nursing actions or judgments." (See *Code for Nurses* [most recent revision—1968], *American Journal of Nursing*, 68:12:2581-2585, December, 1968.) An earlier version of this Code states even more specifically "The fundamental responsibility of the nurse is to *conserve life*, to alleviate suffering, and to promote health." (1960 revision.) Article 4 of the current Code states, "The nurse acts to safeguard the patient when his care and safety are affected by incompetent, unethical or illegal conduct of any person," and the detailed explanation of this principle stresses the fact that "whenever a practice threatens the patient's health, welfare or safety, the nurse has *no choice* but to take appropriate action in his behalf." That nurses have ambivalent feelings about the question of abortion is apparent from a survey that recently appeared in *Nursing '75* (Part 2, of a survey on Death and Dying in which 15,000 plus nurses answered a questionnaire on their opinions, attitudes and practices concerning abortion.) These feelings are also reported in an article "Abortions Unwilling Accomplices," *Human Behavior*, April 1975, p. 42. In the Amicus' opinion, however, the threatened patient in the case of abortion is our "littlest patient," the unborn child, and we must speak out in his defense. In addition, the health and safety of the mother are also at stake.

Mary Cipriano Silva in "Science, Ethics and Nursing" (in the *American Journal of Nursing*, 74:11:2004-2007, November 1974), outlines a number of ethical problems nurses are now facing and will be facing in the near future such as abortion, euthanasia, genetic cloning, "test tube babies" research, and other "future shock" procedures. She also emphasizes the necessity for each nurse to develop her own personal code of ethics which will enable her to cope with these problems.

In all of the controversy, emotional outpouring and acrimony of both pro- and anti-abortionists, the nurse sees her profession

threatened and "caught in the middle" in many ways. Just the definition of abortion alone, as stated in House Bill 1211, has tremendous implications for nursing:

> Section 2 (1). "Abortion" is the *intentional destruction of the life of an embryo or fetus* in his mother's womb or the intentional termination of the pregancy of a mother with an intention other than to increase the probability of a live birth or to remove a dead or dying unborn child.

Most nurses, and especially maternal and child health nurses, have always realized (and have been taught) that in caring for a pregnant woman one is caring for *two* patients, the woman whom she could see and the unborn child within her whom she could not see, but who could be identified by such things as listening to his heart beat with a stethescope, recording his electrocardiogram or electroencephalogram, or outlining his figure by X-ray or ultrasound! This belief is reiterated in the standards of the Maternal and Child Health Section of the American Nurses Association.

> *Standard II.* Maternal and child nursing practice is based upon knowledge of the biophysical and psychosocial development of individuals *from conception* through the child bearing phase of development and upon knowledge of the basic needs for optimum development. (See "Standards of Maternal and Child Health Nursing Practice," which appears as an appendix to *Maternity Nursing Today*, a textbook published by McGraw-Hill Book Co., 1973.)

With such high standards of care, is it any wonder that the survey made by *Nursing '75* found that 67% of maternal and child health nurses did not approve of discretionary abortions? (Also see Dr. Albert W. Liley's testimony given on May 4, 1974 to

the U.S. Senate's Judiciary Committee's Sub-Committee on Constitutional Amendments—Appendix D—"The Unborn Child as Patient" *Human Life Review* 1:1:108-109, Winter 1975.)

The nurse's biological and physiological background has taught her that human life begins at conception with the *genetic* formation of a new human being. This conceptus is not just a "blob" of protoplasm or undifferentiated cells, but is provided with a complete set of instructions for his or her future development the moment the sperm fuses with the nucleus of the ovum and the DNA of the new set of chromosomes begins to function. This *in vivo* process of fertilization and development of the fertilized ovum into a recognizable human fetus has even been filmed by Dr. Molyuki Hayashi, head of the Department of Gynecology and Obstetrics at Tokyo's Toho University School of Medicine. He is anxious to show this firm to medical students and other students, because "Having seen this film, youngsters will at least know to be awed by the value of life." ("The Beginning of Life," *Time*, June 24, 1974:78-80, with its accompanying photographs.) Two other references worth reviewing are (1) the statements of Dr. Jerome LeJeune, Professor of Fundamental Genetics at the Univerité Rene Descartes in Paris, in "Human Genetics and the Unborn Child" which was included as Appendix C in the first volume of the *Human Life Review*, Winter Number, 1975:1105-1107 and (2) "Sounding Board: Deeper Into Abortion" *New England Journal of Medicine*, 291:22:-1189-90, November 28, 1974.

Few nurses would refuse to give any care to the abortion patient because of their concern for the safety of the mother. In any cooperation with the abortion *procedure*, however the nurse is faced with the fact that human life is being destroyed and that she must accept this fact in making her own decision as to whether or not to become directly involved in the delivery room or operating room of a hospital or special abortion facility. If her ethical, moral, professional, and religious principles convince her that she should have no part in such activities, her con-

science must be respected and no one should be able to compel her to *take* part in such activities. This is *her* constitutional right.

In Missouri, this right to refuse is protected not only by 42 USC 300 a-7, but by Sec. 197.032, Missouri Revised Statutes, and so that right is not considered in detail here, except to state that some nurses who currently work in institutions (hospitals) which perform abortions have commented on the fact that their positions seem to be in jeopardy because of their ethical convictions, even though these are currently protected by law. Harassment can take many forms short of actually "breaking the law" and the Courts should be aware of the practice.

Although amicus feels that the purposeful destruction of our smallest and most vulnerable patients is not an acceptable procedure for those who practice one of the healing professions and that nowhere in the Constitution is a physician or other health care professional given the right to destroy the life of a patient, that matter is not before the Court in this case. But because we have an interest in the future health of women, children and families—especially in the State of Missouri—and because many of these health needs are protected by House Bill No. 1211, we have decided to file this brief in support of appellees.

STATEMENT OF THE CASE

On June 14, 1974 House Bill 1211, which had been passed by the Missouri State Legislature, was signed into law by the governor. This statute defines viability as "that state of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life supportive systems" (Section 2(2)) and prohibits the performance of an abortion in the first trimester of pregnancy without the informed written consent of the woman (Section 3(2)).

It further requires the written consent of the woman's spouse (Section 3(3)) and in the case of an unmarried woman under

the age of 18, the written consent of one parent unless a licensed physician certifies that the abortion is necessary to save the life of a mother (Section 3(4)).

• • • • • • • •

Section 9 of the statute prohibits the use of a saline method of abortion after the first trimester of pregnancy and Section 7 provides that any live infant born as a result of an attempted abortion which was not performed to save the life of the mother, shall automatically become a ward of the state. In addition, House Bill 1211 requires the completion and filing of certain forms containing relevant information regarding each abortion performed (Section 10 and 11), while Section (6(1)) provides that any person performing an abortion who fails to exercise the proper professional skill and care to preserve the life and health of a fetus born alive as a result of such abortion, shall be deemed guilty of manslaughter.

The plaintiffs in this litigation are Planned Parenthood of Central Missouri, which maintains a facility for the performance of abortions in Columbia, Missouri, David Hall, a medical doctor who supervises the abortions performed at the Planned Parenthood facility and Michael Freiman, licensed physician who performs abortions at Barnes and Jewish Hospitals in St. Louis and at Reproductive Health Services, an abortion clinic in St. Louis.

The Complaint alleges that certain provisions of House Bill 1211 are unconstitutional and seeks to enjoin the enforcement of several provisions thereof.

After a trial on the merits, a three judge court held all of the provisions of House Bill 1211 to be valid, except Section 6(1) which was found to be unconstitutionally overbroad. A dissenting judge would have held Sections 3(3), 3(4), 7 and 9 to be unconstitutional but concurred with the majority in upholding the validity of Sections 2 (2), 3(2) and 10. The opinion of the three judge court is reported at 392 F.Supp. 1363.

ARGUMENT

I

The Provisions of House Bill 1211 Requiring the Informed Written Consent of the Patient and/or Spousal or Parental Consent Where Appropriate, Are Consistent With Good Nursing Practices and the Judgment of the District Court Upholding These Provisions Should Be Affirmed.

Nurses frequently are left with the problem of attempting to deal with the psychological and emotional trauma which may result when the required consent procedures have not been observed.

Interestingly enough the following quote appears in one of the current textbooks in nursing (Clausen, et al, **Maternity Nursing Today,** MacMillan Co., 1973, p. 117) written in support of the "poor" father. It would seem to apply equally well when the abortion decision is being considered.

> "As females have suffered so long from sexism, so have males. An aspect of this is the neglect of the husband as an important factor in the pregnancy situation after conception takes place. Generally speaking, he is still ignored as a significant part of the human matrix involved in pregnancy. This carries over into the common tendency to ignore him as a significant parent, except for his financial contribution and 'male role image' in parenthood. All members of the family suffer from this."

So, too, do the members of the family suffer if he is ignored in the abortion decision. After all, he does have a 50% stake in the baby since one-half of its genes were in his sperm and even its sex is determined by whether he donates an X or Y sex chromosome!

In addition, the grieving process the aborted patient goes through is entirely overlooked by the appellants (since they do not care for the patient in the weeks following an abortion), as well as the support she needs from family and friends at this critical time. The husband can be a very positive support in assisting her through this most difficult period if he has had a part in her decision. If it has been made without his consent or knowledge, difficulties are compounded a hundred-fold! Supportive parents can play the same role for the adolescent, if given the opportunity.

The following articles from the *American Journal of Nursing* give information about the grieving process experienced by the majority of women who have had still births or early termination of a pregnancy:

1. Yates, Susan A., "Stillbirth—What a Staff Can Do," *A.J.N.*, 72:9:1592-1594, September, 1972.
2. Johnson, Joan Marie, "Stillbirth—A Personal Experience," *A.J.N.*, 72:9:1595-1596, September, 1972.
3. Seitz, Pauline M. and Louise H. Warrick, "Perinatal Death—the Grieving Mother," *A.J.N.* 74:11:2028-2033, November, 1974.

That the mother who has had an abortion—even a therepeutic one—goes through the same grieving process is well supported by Donovan, et al., "Post Abortion Psychiatric Illness," *Nursing Digest*: September/October, 1975:12-16. The nursing implications are covered on p. 17. Other studies have pin-pointed the same problems.

Another article by Curtis, Frances L.S., "Observations of Unwed Pregnant Adolescents," *A.J.N.* 74:1:100-102, January, 1974 gives some insight into the social problems involved in the care of these youngsters.

The Supreme Court in *Roe* and *Doe* enumerated many factors which must be weighed by a woman who is considering an abortion, and concluded that ". . . All these factors the woman and her *responsible* physician necessarily will consider in consultation."

The District Court stated: "Given the fact that even with counseling the decision to terminate a pregnancy is often a stressful one, *it is imperative that a woman be well advised of the options available and* the physical and psychological ramifications of choosing a particular course of action."

The District Court went on to say: "It is clear from this Court's opinion that, although the abortion decision is to be made in connection with a responsible physician, *the ultimate decision is not the physician's to make*. The consent requirement of Section 3(2) assures that the pregnant *woman retains control* over the discretions of her consulting physician." (Emphasis ours.)

This would seem to be a most important provision to protect the pregnant woman from exploitation. Abortion may seem to be a very attractive "way out" of a difficult situation if one does not fully understand its implications. Many women have opted *against* abortion when they have thoroughly understood that abortion takes the life of a child, no matter at what stage of its prenatal development. This seems to be one of the aspects of abortion *least* understood by the pregnant woman, especially if she is a member of a minority group, poorly educated, and if abortion has been encouraged by those interested in population control (regardless of the method) or perhaps by an interest in their own pocketbooks. One clinic patient commented that she had almost decided to have an abortion until she saw a poster that made her realize that the unborn baby at her particular stage of pregnancy could experience pain and other sensations and might be able to cry. She concluded: "I could never live

with myself if I did that to a *baby*!" (Personal communication of a clinic nurse.)

While Section 3(2) may imply counseling by a physician to assure informed consent, it does not rule out counseling by other professional health care personnel. It has been the experience of nurses that frequently the counseling given by physicians is inadequate because of the time element involved. The busy physician simply does not have enough time to spend with the potential abortion patient to be sure she understands all of the open options—especially since she is always very emotionally involved and may not take in all of his statements the first time they are presented. In addition, most physicians have the previously acquired habit of leaving the actual *care* of the patient (*psychological* and *emotional* as well as physical) to the nurse!

Nursing duties and responsibilities toward the pregnant woman have always included counseling and health teaching as well as physical care. In fact, a pregnant woman might seek guidance from a nurse friend, a nurse practitioner, or a nurse in a health agency even *before* approaching her doctor. A nurse, therefore, should be knowledgeable concerning all the options open to the woman who seeks her counsel, especially resources which are available in her own city. We believe that the nurse should be able to discuss all possible alternatives with a patient, including the option of *not* to have an abortion. If the woman has not seen her physician she should be advised to do so at once. Referral can also be made to any of the available facilities which have been set up to assist the potential mother to meet her responsibilities in the matter. The possibility of giving up the baby for adoption should also be discussed. (See: "Because I loved you, Jennifer," *A.J.N.* 74:3:471, March, 1974. Also see "Birthright: Alternative to Abortion," *A.J.N.* 75:1:76-77, January, 1975.)

Two other articles illustrate the problems of the unmarried nurses who did opt for abortion, but were torn by many

conflicting emotions. If they had had further counseling and supportive care (even though professional nurses themselves) their experiences might have been different. (See "Personal Experiences at a Legal Abortion Center," *A.J.N.* 72:1:110-112, January, 1972, and "Does Anybody Care?" *A.J.N.*, 73:9:1562-1565, September 1973, which illustrates the patient's desperate need for supportive care.)

II

Section 6(1) Should Have Been Held to Be Constitutional Since It Is an Accurate Statement of the Professional Responsibility of Any Doctor or Nurse Attending a Patient Who Gives Birth to a Live Child.

Any discussion of Sec. 6(1) requires a consideration of Sec. 2(2) which defines *viability* as:

> "that stage of foetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life support systems."

This definition has been challenged "because it fails to distinguish between trimesters of pregnancy and because it would have the result, when read in conjunction with Section 5:

> 'No abortion not necessary to preserve the life or health of the mother shall be performed unless the attending physician first certifies with reasonable medical certainty that the fetus is not viable.'

of forbidding non-therapeutic abortions at an earlier point than is constitutionally permissible *under Roe and Doe*."

We concur with the opinion of the District Court declaring that Section 2(2) is essentially the same as the definition set forth in *Roe and Doe* and that it is even more restrictive be-

cause of the insertion of the word "indefinitely." (Also see definition of viability from Rules and Regulations, *Federal Register* 40:154, Friday, August 8, 1975.) We should like to add that the term "viability" is, from a medical standpoint, fast becoming an archaic term, because of the rapid scientific advances that are being made today. "Viability" as defined in House Bill No. 1211, however, would seem to make the necessary provision for all eventualities.

Section 6(1) was declared overbroad for failure to exclude the stages of pregnancy prior to viability, and was therefore declared unconstitutional.

This Section requires attending medical personnel to take positive action only subsequent to an abortion in the event the fetus is aborted alive. The Court, however, declared it to be unconstitutional.

The standard of "viability" should not be required for this section. Aborted foetuses under the age of viability have been known to be kept alive for as long as possible in order to carry out experimentation. This is *not an accepted standard* of medical or nursing care for the living fetus, even though it is certain that he will eventually die. Surely he is entitled to as much care as that received by any premature infant. It must be remembered that the fetus is capable of feeling pain at a very early gestational age. Electrocardiographic tracings can be made at the age of four weeks, electroencephalographic tracings at six weeks. At eight weeks he will grasp a forceps placed in his hand, and a 12 week fetus definitely responds to pain and noxious stimuli if he should happen to be born alive. Is it the purpose of the Court to deliberately hasten his death or to see him suffer? It is this eventuality that Section 6(1) might also be interpreted to cover and is a logical extension of 6(3) which forbids such research and which up to this point has not been challenged by the plaintiffs as unconstitutional.

It is impossible for anyone to set a specific time at which an infant becomes viable for each case may be different. While the Supreme Court stated that "viability is *usually* reached at 24-28 weeks," it should not desire to be locked in to medieval medicine by making a firm pronouncement that sets a definite time limit. Several cases have been reported in which the life of an infant born at 20 weeks gestation has been successfully maintained. (See Dr. and Mrs. J. C. Wilke, *Handbook on Abortion*, Hiltz Publishing Co., Cincinnati, Ohio, p. 21.)

With the increasing expertise of the obstetrician, pediatrician and nursing specialist and the increasing sophistication of life support systems, the threshold of viability may be pushed back even farther in the future. The plaintiffs apparently were well aware of the fact, or they would not have attempted to protect themselves by requesting "the 24th week" as a definition of viability. Even at the present time, viability is determined more by the weight of the fetus than by its age. (See "Report to the National Committee for Protection of Human Subjects," March, 1975, by Richard E. Behrman.)

Because the infant at the threshold of "viability" is a very fragile being and a high risk patient, the proper life support systems and personnel should be on hand at the time of the surgery (especially if a hystereotomy is performed) to give him the best chance of survival. If the infant is alive, the mother has already abandoned all claim to him according to Section 7, and he automatically becomes a ward of the State. Therefore, any procedure done to deprive him of his life or to hasten his death would be homicide.

The determination of "viability" in any particular case is the physician's responsibility and he should take it seriously. Any child born alive also automatically becomes a *nursing* responsibility, since the nursing care the infant receives immediately in the delivery room becomes important in the preservation of his life.

III

Medical Evidence Supports the Finding of the District Court That the Saline Method of Abortion Is Detrimental to the Woman's Health and Its Use Should Be Prohibited After the First Trimester of Pregnancy.

Appellants contend that Sec. 9 is invalid for the reason that it invades the province of the physician by restricting his exercise of medical judgment in performing abortions. But their real reason is the fact that saline abortions are not the procedures of choice during the first 12 weeks of pregnancy, and are rarely used before the 16th week!

The judgment of the physician is only unfettered during the first 12 weeks of pregnancy. State regulation of the abortion procedure is not invalid after the first trimester unless the reason is not reasonably related to maternal health. The record of the trial shows that the use of the saline method exposes a woman to the danger of severe complications regardless of the skill of the physicians or the precautions taken.

Safer alternative procedures are available such as prostaglandins, mechanical means of inducing labor, etc.

The Court quite properly concluded that: "The proscription against use of saline amniocentesis is reasonably related to maternal health and is, therefore, within the power of the legislature."

One statement by the dissenting judge regarding the saline method struck us as being particularly illogical. The Judge said: "I cannot agree that such regulation is *reasonably related to maternal health;* on the contrary, this seems to be the kind of unwarranted intrusion in medical discretion which the Supreme Court has held infringes upon the patient's constitutional rights." If this judge had ever seen a patient suffering from one of the complications mentioned in the medical evidence we are sure that he would hold that the patient had definite constitutional rights against being exposed to such a

procedure. As a rule she does not realize what she is being subjected to. It is a convenience for the *doctor* to use such a procedure, since he can usually leave the rest of the care of the patient to the nurse and make himself unavailable when the infant is actually expelled. Perhaps this quotation from an article previously mentioned ("Abortions Unwilling Accomplices," *Human Behavior*, April, 1975, p. 19), will give some idea of some of the problems:

> . . . The nurses felt that, after performing abortions, doctors were leaving them with the "dirty work." The cleaning-up process was particularly unsavory after saline-induced abortions performed when the patient is 14 to 20 weeks into the pregnancy. Resident would inject the amnionic sac with saline, then leave the scene. Generally, according to the nurses, the doctors would then make themselves unavailable when, six to 24 hours later, the patient passed the fetus. At times, the aborted fetus had a heart beat and even though it could not survive outside the uterus, the nurses felt torn between giving it oxygen and "assisting in its termination."

If doctors refuse "to be available" when actual expulsion of the fetus takes place, haw can they guard against some of the possible complications which may occur? Skillful as the nurse may be, she is not a doctor and cannot assume full responsibility for the patient's well being. This is an infringement upon *her* constitutional rights!

The best additional recent supporting data which we have found for banning saline amniocentesis is contained in the article "An Evaluation of Abortion Techniques and Protocols," by Drs. Burnett, King, Burkman and Atienza of Johns Hopkins University (*Hospital Practice*, August, 1975:97-105) in which all abortion procedures in use at the present time are outlined and evaluated. The article stresses the fact that *none* of the techniques now in use are perfect and that safer and more efficient methods are urgently required, especially for use during the

second trimester. The article supports the fact that no abortion procedure is really "simple."

The Court concurred that the record keeping required in Sections 10 and 11 was constitutional and justifiable in the light of record-keeping practices. These reports can be considered as restrictive only if the physician or abortion center have something to hide and the request for elimination of these records leaves the motives of the plaintiffs highly suspect. As nurses we are interested in obtaining all pertinent data relating to maternal mortality and morbidity in order to determine nursing needs and to raise standards of nursing care.

CONCLUSIONS

Amicus realizes that much more supporting evidence is available. The selections included herein, however, seem to be sufficiently pertinent to make the point we wish to make—namely, that because of its protective effect on the life and health of the mother who is considering or who has opted for an abortion —Missouri House Bill No. 1211 should be declared constitutional. It is especially important that Sections 3, 6(1), and 9 be retained. Section 3(2) by requiring the written informed consent of the mother protects her from exploitation from those who might seek financial or other gain at her expense, Section 6(1) protects a *living* premature infant from deliberate destruction and Section 9 bans one of the most objectionable and dangerous abortion procedures (saline amniocentesis) after the 12th week of pregnancy.

Respectfully submitted

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